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Running head: WORK-ANXIETIES IN SOMATIC PATIENTS

Prevalence and characteristics of work-anxiety in medical rehabilitation patients – a cross-sectional observation study

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Abstract

Objective: To investigate frequency, type and characteristics of work-anxieties in somatic rehabilitation inpatients. Work-anxieties are serious disorders which affect occupational functioning and often go along with long-term sick leave. Somatic patients may suffer from work-related participation problems due to their chronic health condition. Work-anxieties need specific diagnostic and treatment.

Design: This is a cross-sectional observation study.

Setting: We investigated inpatients from a neurological, orthopedic and cardiologic rehabilitation clinic.

Participants: 1610 patients (18-65 years) were investigated for work-anxieties in a short structured interview.

Main outcome measures: Patients who scored high in at least two out of nine work-anxiety leading symptoms and reported impairment were investigated with a differential-diagnostic interview on work-anxieties, and with the MINI interview on non-work-related common mental disorders. Patients also filled in a self-rating on their subjective symptom load and sociodemographic data.

Results: About 20-27% of the investigated somatic rehabilitation inpatients (altogether n=393) got a work-anxiety diagnosis. Orthopaedic patients report highest work-anxiety and have longest preceding sick leave (20.6 weeks in past 12 months). Orthopaedic patients suffer from work-related adjustment anxieties, social anxieties, and workplace phobia, while cardiology patients are more often affected from hypochondriac anxieties. Anxieties of insufficiency and worrying occur equally in all indications.

Conclusions: About one quarter of somatic rehabilitation patients is in need of additional diagnostic attention due to work-anxieties. Differential diagnostic of work-anxiety is needed for initiating adequate therapeutic action. Somatic rehabilitation physicians should be aware

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of work-anxieties in their patients, especially in orthopaedic patients with preceding long-term sick leave.

Keywords: Workplace, mental health, anxiety, sick leave, work-oriented rehabilitation

Abbreviations:

WAI	Work-Anxiety-Interview
IMET	Index for measuring Restrictions in Participation
WPS	Workplace Phobia Scale
MINI	Mini International Neuropsychiatric Interview

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Introduction

Work-anxieties are serious mental disorders which affect the occupational functioning and often go along with long-term sick leave [1]. Work-anxiety can be empirically distinguished from general (non-work-related) mental health problems [2,3]. Work-anxieties do not only occur in psychosomatics, but also in somatic patients [4]. As a somatic illness may be an additional burden in life, some of these patients may be expected to suffer from work-related participation problems due to their illness condition: After a brain- or cardiac insult or disc prolapse, patients may be afraid that their cognitive or physical achievement capacity will not recover sufficiently for being able to work again. On the other hand, persons with an anxious basic personality may behave exaggeratedly anxious when handling a somatic disorder – and this also affects the life domain "work". Thus, even if there is a reason for anxiety, there may be the problem of "pathological realangst" [5,1,4], i.e. *exaggerated and hindering anxiety* which *impairs a person´s life and work ability*. Therefore also in somatic rehabilitation work-anxieties need specific attention concerning diagnostic and treatment.

According to the general psychopathology of anxiety [6,7], work-anxieties may present in different phenotypes, i.e. work-related adjustment disorder with anxiety (occurring after a threatening event at work, or after onset of an illness which leads to anxiety towards work), social anxiety towards specific colleagues or supervisors, situational anxiety directed to specific work tasks or work places (e.g. computer work, driving), hypochondriac anxiety (i.e. anxiety to become ill due to work, or the illness becomes deteriorated when continuing work), anxiety of insufficiency (i.e. fear not being able to cope with the work content or work amount sufficiently), generalized worrying in the sense of worrying about minor daily hassles at work, and workplace phobia (a complex phobic reaction towards the workplace as a whole with panic-like arousal when approaching the workplace [8]). These work-anxiety types have been observed and validated in different samples and settings [1,2,9,10]). Work

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anxieties may be coded with the ICD-number F 40.8 workplace phobia, or F 41.8 work-related anxiety with predominant [hypochondriac anxiety / situational anxiety / social anxiety / anxiety of insufficiency / worrying].

This present study is the first to explore the frequencies and distribution of different types of work-anxiety in somatic rehabilitation patients.

1. How many patients in somatic rehabilitation treatment before vocational reintegration suffer from work-anxieties? Do these patients with work-anxieties differ from patients without work-anxieties?
2. Next, patients with work-anxieties in three different somatic rehabilitation indications will be compared: neurology, cardiology and orthopaedy. The question is whether work-anxieties are differentially distributed in different somatic indication groups.

Results give hints concerning the need for additional diagnostic and therapeutic action in these somatic indications.

Method and setting

The study was done in three German somatic rehabilitation clinics, i.e. cardiology, orthopaedics and neurology unit, in the period of 04/2012 and 03/2014. Patients with somatic illness are sent to rehabilitation in order to prevent a chronic course of participation and work ability impairment. The aim is to restore or strengthen work ability and daily life participation. Rehabilitation as inpatient treatment lasts for three weeks and covers functional diagnostics, medical, sports, cognitive and psychosocial treatments. Patients suffer from various disorders such as state after a brain or heart infarction, or disc prolapse.

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We investigated patients 3-5 days after intake concerning work-anxieties in a thorough clinical interview, done by a state-licensed psychotherapist experienced in rehabilitation diagnostics and treatment. The study has been reviewed and approved by the ethics committee of the University of Potsdam, Germany.

All investigated patients were in age of 18-65 years old and in a somatic state in which return to work is an adequate topic for treatment. Acute psychotic, manic or somatically acute patients were not invited for study participation. Participants were recruited as follows: 1619 unselected routine patients fulfilling the mentioned criteria got a date for a screening interview of 20 minutes into their rehabilitation time schedule. The screening interview was done by the state-licensed psychotherapist three days after intake in personal contact. Nearly all (*N*=1610) from the invited patients participated with written informed consent. In the screening interview they were asked for their occupational situation, socio-medical status, and sick leave duration in the past 12 months. They also answered a short self-rating screening on work-anxieties [11]). Patients who scored with "2" (rating 0-4) or higher in at least two of nine items of the work-anxiety screening questionnaire and who reported to suffer from or be impaired by these work-anxiety symptoms were interviewed in an additional structured diagnostic interview on the differential diagnostic of work-anxieties (Work-Anxiety-Interview WAI [1,2]). A work-anxiety diagnosis (WAI) can only be made in patients who scored in the work-anxiety screening.

All patients with work-anxiety diagnosis (WAI) and a random selection of patients who did not score in work-anxiety screening were asked to fill in an additional self-rating questionnaire on general wellbeing (WHO-5 [12], WHO, 1998), perception of illness-related impairment (IMET [13,14]) and specific

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workplace phobic anxiety (WPS [1]). Thus a comparison of patients with work-anxiety diagnosis (WAI) and patients without clinically relevant work-anxiety can be done.

Work-Anxiety-Interview

Patients with higher scores in work-anxiety screening who reported to suffer from these anxieties were seen in an additional structured interview on specific workplace-related anxieties (*Work-Anxiety-Interview* WAI [1,2,4]). The WAI interview covers different psychopathological anxiety qualities, i.e. workplace-related situational anxiety, hypochondriac anxiety, social anxieties, anxiety of insufficiency, general worrying, adjustment disorder and workplace phobia. The interview was validated in several studies with different anxiety questionnaires and psychopathology scales as measures for convergent and divergent validity [4]. The inter-rater reliability was kappa = .97 (N = 106).

For descriptive purposes, non-work-related mental disorders, i.e. present and lifetime mental disorders, were examined with the *Mini International Neuropsychiatric Interview*, MINI [15]. The MINI is an internationally evaluated instrument to make research diagnoses for the full range of mental disorders according to DSM [6].

Index for the Measurement of Restrictions in Participation

The *Index for the Measurement of Restrictions in Participation*, IMET [13,14] is a self-rating instrument on illness-related restrictions in participation. It covers: 1. activities of daily living (washing, easting etc.), 2. activities at home (housework, gardening etc.), 3. outside the home activities (shopping, driving around etc.), 4. Duties (cleaning up, care of others etc.), 5. recreational activities (sports, leisure time etc.), 6. Social activities (meeting friends, theatre etc.), 7. close relations (partner, family etc.), 8. Sexual life (quantity and quality), 9. coping

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with stress, 10. work and professional activities. The patient is asked to make a rating for each item on a numeric rating scale, ranging from 0 = no impairment to 10 = no activity possible any more.

Workplace Phobia Scale

Work-anxiety was measured with the *Workplace Phobia Screening*, WPS [1], a self-rating scale for measuring the global tendency of work phobic anxiety and workplace avoidance behaviour. It contains 13 items. The WPS is given to the patients with the title 'questionnaire on workplace problems' which examines 'behaviour, thoughts, and feelings which can occur in relation to the workplace'. The rating is a Likert-scale ranging from (0) no anxiety to (4) heavy anxiety.

WHO-5

Wellbeing was measured with the WHO-5 wellbeing-rating [12] which asks whether the patient feels well, relaxed, active, and full of interest for life. The rating of each of the five items is done on a six step scale from (5) I feel like this all the time to (0) I never feel like this.

Global rating on attribution of health problems

A global question on the degree of externalising attribution of health problems onto work was asked as follows: "To which degree do you believe your work has caused or forced your health impairments?"

Statistical analysis

Frequencies of occurrence of the different work-anxieties are reported. Patients

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with and without work anxieties are compared with t-Test and X^2-Test. Next, cardiology, orthopaedic and neurology patients are compared for differences in the distribution of work-anxieties and socio-medical and work status. ANOVAs have been calculated for comparison of the three somatic patient groups concerning additional descriptive continuous variables (symptom load, impairment).

Results

Table 1 shows the flow of patients over the steps of investigation. The majority of patients who scored in the work-anxiety screening but did not participate in the WAI had from clinical impression good work coping and no clinically relevant work-anxiety must be expected (64.4%, *n* = 235+22, Table 1). However, a part must be expected to have serious problems with work-anxiety and work avoidance (13.5%, *n* = 17+37, Table 1). These patients could not be further investigated and thus are missing in the variance of the sample.

[insert table 1 about here]

Table 2 shows the basic descriptive characteristics of all investigated patients from the three somatic indications.

[insert table 2 about here]

Most of the patients are presently employed (74-78%) and report similar degrees

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of self-reported (work ability) impairment (IMET), and general wellbeing (WHO-5). Orthopaedic patients in comparison to the others have more often been on sick leave during the past 12 months as compared to cardiology or neurology patients. They have the greatest number of applications for disability pension, have longest sick leave durations in the past year (18 weeks). They attribute their health problems more strongly to the work context than do patients from cardiology or neurology. Work-anxiety (WPS) shows moderate correlations with work impairment (IMET work $r = .372^{**}$, $n = 461$), impairment in general (IMET $r = .392^{**}$, $n = 471$), and general wellbeing (WHO-5 $r = -.350^{**}$, $n = 454$).

Comparison of patients with and without work-anxiety

Before assuming patients with work-anxieties as a specific risk-group in need of additional diagnostic and therapeutic attention, it shall be investigated whether the patients with work-anxiety diagnosis are different from patients without work-anxieties (Table 3).

[insert table 3 about here]

Patients with work-anxiety diagnosis are socio-medically more problematic than patients without work-anxiety: They have more often applied for disability pension (17.8%), have longer sick leave durations during the time before rehabilitation (10.15 weeks), and they attribute their health problems more strongly (45.7% of health impairments caused or forced by work) to the workplace than do patients without work-anxiety. Work-anxiety patients reported higher work-anxiety symptom load (WPS) and impairment (IMET), and a lower

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general wellbeing (WHO). In both groups more than ¾ were employed. Concerning the distribution of professional fields, patients with work-anxiety diagnosis were more often employed as white collar-employees, while the patients without work-anxieties there were more often blue-collar-workers. Patients with work-anxiety diagnosis were on average a little younger, and there was a higher rate of women.

Patients with work-anxiety diagnosis in different somatic indications

About half (n = 828) of the 1610 screened patients in working age had a higher score in at least two items of the work-anxiety screening. From those, 429 said that they suffered from these work-anxieties or had impairments at work, and agreed to participate in the work-anxiety differential diagnostic interview. Then 393 patients fulfilled the criteria of at least one work-anxiety diagnosis (WAI, Table 1,3).

In the three different indicative groups a similar amount of 20.0 to 27.7% of the initially investigated patients fulfilled the criteria of at least one diagnosis of work-anxiety in the structured Work-Anxiety-Interview (WAI). Table 4 shows the characteristics and comparisons of the patients with work-anxiety diagnosis from the three indicative groups.

[insert table 4 about here]

Orthopedic patients thereby have the highest number of work-anxiety diagnosis (M = 2.12) in the Work-Anxiety-Interview (WAI), and the highest work-anxiety self-ratings (WPS M = 1.61). They also have the highest rate of applications for

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disability pension, the longest sick leave durations in the past 12 months (20 weeks) and highest level of work-directed attribution of health problems. In contrast, there were no differences in general wellbeing (WHO-5) and impairment perception (IMET) between the three groups.

65-76% of the patients with work-anxiety diagnosis also had a general mental disorder in the MINI interview. This means that about 30% of the patients with work-anxiety diagnosis did *only* suffer from the *specific work-anxieties* without comorbid (non-work-related) common mental disorder.

Table 5 shows the distribution of work-anxiety diagnosis in the different indicative groups. Concerning generalized worrying, anxiety of insufficiency and situational anxiety, there were no differences between the three groups. However, there are some work-anxieties which were differently distributed in orthopeadics, neurology and cardiology patients: Workplace phobia (22%), specific social anxiety (38%) and adjustment disorder with anxiety (23.5%) occured most often in orthopaedic patients. Highest rate of hypochondriac anxiety were found in cardiology patients (14.9%).

[insert table 5 about here]

Discussion

Epidemiologically it has been found that 22% of patients with cardiac illness suffer from comorbid mental disorders. In a sample of musculo-skeletal patients

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the prevalence was 28.4% [16]. As this present investigation focused on detecting work-anxieties, we cannot give epidemiological data on the distribution of general (non-work-related) mental disorders over all initially investigated patients here. But, even more important concerning vocational integration-orientation, we can describe the specific characteristics of work-anxieties in different groups of somatic patients.

The rate of patients with clinically relevant work-anxiety diagnosis (according to WAI) of 20-27% from the overall sample shows that there is a *relevant need for vocational-oriented diagnostic and therapeutic action in somato-medical rehabilitation*. This adds to the literature which pointed out to the phenomenon of mental health comorbidities in somatic patients [17], but did until now not focus on work-anxieties in particular. However, work-anxiety, especially workplace phobia, is more narrowly related with socio-medical work-problems than the common non-work-related anxiety disorders [1]. Next, the present study has shown that patients with work-anxiety diagnosis are the socio-medically "more severe" patients than patients without work-anxieties. Somatic patients with work-anxiety have longer previous sick leave durations, have more often applied for disability pension, report more severe symptom load and impairment, show stronger (dysfunctional) attribution of health-problems on work, and thus they are more in need of help concerning vocational reintegration.

The data have shown that one third of the patients with work-anxiety diagnosis do *only suffer from this specific work-anxiety* (and no comorbid common mental disorder). This underlines again what has been shown in other samples: work-anxiety must be explored and diagnosed specifically, and work-anxieties can and

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must be distinguished from non-work-related mental disorders or other stress-reactions [2,8]. Thus, in order to focus this additional socio-medical problem of work-anxiety in somatic medicine more adequately, it makes sense to call work-anxiety what it is, e.g. “work-related anxiety” (F 41.8, or in case of event-relatedness F 43.2) [18], or “workplace phobia” (F 40.8) [9], and do not subsume it under general common mental disorders such as depression or non-work-related anxiety disorder such as agoraphobia.

All types of work-anxiety diagnosis can be found in each somatic indication, with the *orthopaedic sample* containing patients with work-anxiety diagnosis in about the same frequency (like cardiology and neurology), but on an even more intensive and impairing level. This concerns especially the frequency of specific social anxieties and workplace phobic avoidance anxiety. Orthopedic patients with work-anxiety diagnosis also have longest previous sick leave durations (20 weeks). Thus, work-related early diagnostic and interventions should especially be a task in orthopaedics. A physician talking with the patient about his professional situation early in the course and strengthening motivation for return to work is important for setting the course in a fruitful way. Patients take things earnest that physicians tell them. Therefore it is also the job of the somatic physician not to support continuous dysfunctional attributions (like “work caused my health problems”, or “stress at work is dangerous to health”) and avoidance behaviour of a patient (which in case of work-anxiety may lead to long-term sick leave and disability pension). Instead, somatic physicians may express towards their patients that return-to-work-activities are important in treatment (beside the somatic treatment). It has been shown in orthopedic setting that early

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interventions are necessary for avoiding the development of maladaptive cognitions in patients and a negative course [19].

The present investigation has been conducted in a naturalistic somato-medical rehabilitation setting in which an orientation on vocational reintegration is included. Data are therefore of great ecological validity. Patients are typical rehabilitation patients in workable age. They have been investigated at a stage of illness and treatment course in which the question for work ability, vocational reintegration and return to work becomes relevant. Sample characteristics of all patients seen in the screening interview were similar to other reports [20-23]. Therefore the investigated patient sample can be understood as representative for somatic rehabilitation patients in a state which allows the question for work reintegration. The vocational problems which have been explored in the interviews are not only of structural nature, nor are they purely somato-medical or general mental health problems. They are in core specific work-anxieties and require concrete attention for preventing the patients become long-term suffering or impaired.

Limitations

This study does not allow any causal interpretation of etiology of work-anxiety. Further longitudinal research including analysis of work conditions is needed. Thereby also the course of somatic illness development and work-anxiety development in parallel are of interest.

Since we investigated a routine sample of somatic rehabilitation patients from different indications, generalizability is limited to rehabilitation patients of cardiology, orthopedics and

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neurology who are in a health state for which vocational reintegration is an adequate aim. Concerning the number of patients with work-anxiety diagnosis, there may be a slight bias: Some patients have avoided the Work-Anxiety-Interview (13.5% of those with work-anxiety tendency in initial screening, n=17+37, Table 1) and may be missing in the group of patients with work-anxiety diagnosis. Thus, the here reported rate of patients with work-anxiety diagnosis must be understood as a rather conservative estimate.

Conclusion

Our data show that about a quarter of somatic rehabilitation patients is in need of additional differential diagnostic attention concerning work-anxieties. In order to avoid long-term sick leave and deterioration of work-anxiety problems in the long-run [24], is makes sense to start speaking about the topic “work” with these patients even parallel to a primarily indicated medical treatment [11].

Understanding the differential diagnostic of a work-anxiety problem (i.e. is it anxiety of insufficiency due to the health problem, or is it a problem of social interaction anxiety) is necessary for choosing adequate therapeutic strategies.

Somatic rehabilitation physicians should be aware of work-anxieties in their patients, especially in orthopaedic patients with preceding long-term sick leave. Screening instruments helping to identify patients of risk are available [1,2,25].

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Table 1. Patients flow from screening to self-rating questionnaire

Steps of work-anxiety diagnostic	***N***
Patients in working age who got a screening interview in their time schedule and could be contacted personally	1619
Patients who participated in the screening interview	1610
Patients who scored in work-anxiety screening (high scores in at least 2 items in work-anxiety screening) and thus fulfilled criteria for further exploration with Work-Anxiety-Interview (WAI)	828
Patients who scored in work-anxiety screening and participated in the differential diagnostic Work-Anxiety-Interview (WAI)	429
Patients who fulfilled the criteria of at least on work-anxiety diagnosis in the Work-Anxiety-Interview (WAI)	393
Patients who scored in work-anxiety screening but did not participate in the differential diagnostic Work-Anxiety-Interview (WAI)*	399
***Reasons for declining or being excluded from Work-Anxiety-Interview (WAI)**	399
Patient says s/he has good work coping and does not need further exploration or therapy	22
Patient says s/he has no clinically relevant suffering or severe impairment	235
Medically or cognitively severely impaired patient, excluded by interviewer	13
Patient had sufficient diagnostic and psychotherapy at home	2
Somatic health shall be focused first	4
Does not “want” to work any longer, avoid work, disability pension planned	17
Professional perspective already cleared, no diagnostic necessary	2
Want to avoid topic work and a work-directed interview is „too much“	36
negative vocational prognosis says physician	13
Early retirement regularly	17
Refused after reading patient information	4
Had bad experiences with psychotherapist earlier	1
Does not believe in data security	1
Language problems	1
No reasons expressed	31

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Table 2. Socio-demographic and socio-medical characteristics of the three somatic patient samples. Means (standard deviation) for continuous variables or percentages for categorical variables are reported.

	Cardiology	**Orthopedics**	**Neurology**	**Significance of difference *p* in X^2-Test or ANOVA (Bonferroni corrected)**
All patients	***N*=505**	***N*=290**	***N*=815**	
Age	53.54 (7.3)	51.99 (7.6)	50.30 (9.5)	[a] .041 [b] .000 [c] .012
Women	25.9%	69.7%	43.9%	.000
Presently employed	77.4%	74.4%	78.7%	.331
Application for disability pension	2.9%	7.6%	3.8%	.001
Any time of unfitness for work during the past 12 months	47.3%	71.0%	43.7%	.000
Patients with increased score of work-anxiety in a work-anxiety screening	247 48.9%	167 57.6%	414 50.8%	.070
Cumulated weeks of unfitness for work in the past 12 months	6.11 (13.15)	18.78 (32.25)	5.35 (12.85)	[a] .000 [b] 1.000 [c] .000
Degree of externalising attribution of health problems on work (rating 0-100)	24.84 (29.2)	39.01 (34.04)	20.77 (28.3)	[a] .000 [b] .055 [c] .000
Patients´ self-rating on symptom load and impairment**	**Cardiology**	**Orthopaedics**	**Neurology**	**Significance of difference *p* ANOVA (Bonferroni corrected)**
Wellbeing WHO-5	2.40 (1.30) *n*=244	2.12 (1.08) *n*=134	2.19 (1.19) *n*=431	[a] .097 [b] .088 [c] 1.000
Impairments overall IMET	3.30 (2.42) *n*=182	4.04 (2.38) *n*=103	3.37 (2.16) *n*=350	[a] .025 [b] 1.000 [c] .028
Impairment in work ability IMET	5.15 (3.50) *n*=175	5.58 (3.28) *n*=102	5.38 (3.23) *n*=343	[a] .895 [b] 1.000 [c] 1.000
Workplace Phobia Scale WPS	0.73 (0.85) *n*=247	0.94 (1.07) *n*=136	0.87 (0.89) *n*=433	[a] .090 [b] .177 [c] 1.000

Note: [a] = significance of difference between cardiology and orthopaedics $p<.05$, [b] = significance of difference between cardiology and neurology $p<.05$, c = significance of

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difference between orthopaedics and neurology $p<.05$.). **Patients who got a work-anxiety diagnosis in the WAI, and a random cohort from those who did not score in the screening interview filled in the additional self-rating questionnaire (WPS, WHO-5, IMET).

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Table 3. Work characteristics and symptom load: Comparison of patients with work-anxiety diagnosis according to Work-Anxiety-Interview (WAI) and patients without clinically relevant work-anxiety. Means (standard deviation) or relative frequencies are reported.

	Patients with work-anxiety diagnosis (WAI) *N*=393	**Patients without clinically relevant work-anxiety* *N*=752**	**X^2-Test or t-Test for differences between the two groups *p***
Age	49.98 (8.45)	51.76 (8.98)	.001
Gender: Percentage of women	52.7%	40.0%	.000
Work-related characteristics	***n=393***	***n=752***	
Obtaining workplace presently	79.5%	81.9%	.330
Current profession			.003
- Unskilled	5.3%	9.7%	
- Blue-collar-worker	24.9%	30.4%	
- While-collar-employee	59.5%	49.1%	
- High qualified employee with leading position	2.3%	2.9%	
- Freelancer	7.4%	7.9%	
Duration of sick leave in weeks in the past 12 months before rehabilitation	10.15 (16.93)	4.72 (11.70)	.000
Certified degree of impairment or applied for	48.9%	39.6%	.019
Applied for disability pension	17.8%	2.0%	.000
To which degree do you believe your work has caused or forced your health impairments? (Rating 0-100)	45.77 (30.27)	10.49 (20.1)	.000
Symptom load	*****n=362***	******n=234***	
Workplace phobic anxiety WPS	1.28 (0.94) *n*=362	0.15 (0.28) *n*=234	.000
General wellbeing WHO-5	1.87 (1.10) *n*=358	2.79 (1.23) *n*=229	.000
Illness-related impairment IMET overall	4.06 (2.15) *n*=357	2.24 (2.18) *n*=114	.000
Illness-related impairment IMET work	6.15 (2.94) *n*=351	3.46 (3.48) *n*=110	.000

Note: *Only patients who did not score in work-anxiety screening or did not get a diagnosis in WAI are included in this column (399 patients who scored in work-anxiety screening but did not undergo the WAI interview were excluded, as well as patients who were unclear in work-anxiety screening due to missings).**From 393 patients who got a work-anxiety diagnosis in the WAI, 362 filled in the additional self-rating questionnaire. ***From patients who did not score in work-anxiety in the screening interview a random cohort was asked to fill in the additional self-rating questionnaire.

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Table 4. Patients with work-anxiety diagnosis according to Work-Anxiety-Interview (WAI): Socio-demographic and socio-medical characteristics of the three somatic patient samples. Means (standard deviation) for continuous variables or percentages for categorical variables are reported (*N*=393)

	Cardiology	**Orthopedics**	**Neurology**	**Significance of difference *p* in X^2-Test or ANOVA (Bonferroni corrected)**
Patients with workplace-related anxiety diagnosis (WAI) (percentages are related to the initial full sample reported in Table 1)	***n*=101 20.0%**	***n*=68 23.4%**	***n*=224 27.5%**	
Number of work-anxieties according to diagnostic interview	1.35 (0.88)	2.12 (1.42)	1.69 (1.13)	[a] .000 [b] .023 [c] .017
Accompanying general mental disorder (non-work-related mental disorders acute or lifetime)	65.3%	76.5%	75.4%	.129
Age	51.90 (6.8)	50.91 (8.00)	48.84 (9.1)	[a] 1.000 [b] .007 [c] .022
Women	30.7%	80.8%	54.0%	.000
Presently employed	76.0%	69.1%	84.3%	.015
Application for disability pension	3.9%	13.2%	5.4%	.000
Any time of unfitness for work during the past 12 months	61.3%	82.4%	57.6%	.001
Cumulated weeks of unfitness for work in the past 12 months	8.06 (14.26)	20.59 (21.07)	7.92 (15.05)	[a] .000 [b] 1.000 [c] .000
Degree of externalising attribution of health problems on work (rating 0-100)	46.11 (28.8)	61.23 (26.9)	40.95 (30.4)	[a] .004 [b] .457 [c] .000
Workplace Phobia Scale WPS	1.06 (0.81) *n*=92	1.61 (1.00) *n*=55	1.28 (0.96) *n*=215	[a] .002 [b] .180 [c] .061
Wellbeing WHO-5	2.01 (1.18) *n*=91	1.76 (0.93) *n*=55	1.83 (1.09) *n*=212	[a] .572 [b] .533 [c] 1.000
IMET Impairments overall	4.16 (2.39) *n*=91	4.58 (2.12) *n*=54	3.89 (2.02) *n*=212	[a] .765 [b] .933 [c] .104

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IMET Impairment in work ability	6.38 (3.18) *n*=91	6.26 (2.76) *n*=54	6.02 (2.88) *n*=212	[a] 1.000 [b] .992 [c] 1.000

Note: [a] = significance of difference between cardiology and orthopedics; [b] = significance of difference between cardiology and neurology; [c] = significance of difference between orthopedics and neurology.

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Table 5. Different types of work-anxieties in patients with work-anxiety diagnosis according to Work-Anxiety-Interview (WAI) from cardiology, orthopedics and neurology (*N*=393).

Type of work-related anxiety	**Cardiology *n*=101**	**Orthopedics *n*=68**	**Neurology *n*=224**	**Significance of difference *p* in X^2-Test**
Adjustment disorder with anxiety	7.9%	23.5%	15.6%	.019
Specific social anxiety	14.9%	38.2%	26.3%	.003
Situational anxiety	35.6%	29.4%	37.9%	.437
Hypochondriac anxiety	14.9%	11.8%	6.7%	.057
Anxiety of insufficiency	25.7%	35.3%	32.6%	.345
Generalised worrying	25.7%	33.8%	34.8%	.258
Workplace phobia	7.9%	22.1%	11.6%	.020

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